



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

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120 South Stockton Street, Lower Level
Trenton, NJ 08611-1730

TO: Assisted Living Residences/Assisted Living Programs/Comprehensive Personal Care Homes, Registered Nurses and Pharmacists

FR: Pamela Z Gendlek – Program Manager Health Facilities Assessment & Survey

RE: Medication Aide (Med Aide) Instructor Training Workshops
(NEW INSTRUCTORS OR IF YOU ATTENDED A WORKSHOP BEFORE 2003)

Friday April 24, 2009. Registration begins at 8:00 a.m.; workshop ends at approximately 4:00 p.m.

REQUIREMENTS: 1. Currently licensed as a registered professional nurse (RN) **in New Jersey**; 2. Possess at least two (2) years of full-time or full-time equivalent clinical experience including medication administration responsibilities, or at least two (2) years of full-time or full-time equivalent experience teaching nursing courses within the past five (5) years; 3. Consultation/Collaboration with a NJ Registered Pharmacist (RPh) required when providing CMA courses. Pharmacists must be registered in New Jersey. Both the RN and the RPh will be required to bring their current licenses (**not a copy**) with them on the day of the Workshop. The course is approved for six (6) live law credits by the Board of Pharmacy.

A set of two course manuals, one developed for the RN/RPh Trainers and one developed for the Medication Aide Trainee, and a comprehensive set of handouts will be distributed at the Workshop. The cost to attend is \$50.00 **per attendee**, is **non-refundable**, and a check to cover the course manuals and handouts must accompany this registration form. Please make **checks** payable to **New Jersey Department of Health and Senior Services**.

Respond by Thursday, April 9, 2009. Please note that the workshop is filled on a first come first served basis and may reach capacity prior to **April 9th**. Upon approval, a confirmation notice and directions will be mailed to the attendee's home address during the week of **April 13, 2009**. Please detach the bottom portion of this form, **attach it to your resume** (for each RN and each RPh), and mail to the Certification Program at the above address. Thank you.

QUESTIONS? (609) 633-8981

Registration Form – Med Aide Workshop –April 24, 2009- **INCLUDE RESUME(S) & CHECK (SEE ABOVE)**

Name of RPh _____ License # _____
Pharmacy Affiliation _____ E mail _____
Daytime telephone # (include area code) _____ E mail _____
Previously attended Workshop ☐ Yes ☐ No

Name of RN _____ License # _____
Facility/School Affiliation _____
Daytime telephone # (include area code) _____ E mail _____

NOTE: State policy prohibits DHSS from serving food or drink to regulated parties. Please bring a bag lunch and your own hot beverages. Cold beverage vending is available.